

AMENDED IN ASSEMBLY SEPTEMBER 4, 2015

AMENDED IN ASSEMBLY AUGUST 31, 2015

AMENDED IN ASSEMBLY JULY 16, 2015

AMENDED IN ASSEMBLY JULY 2, 2015

AMENDED IN SENATE JUNE 1, 2015

AMENDED IN SENATE APRIL 21, 2015

AMENDED IN SENATE MARCH 26, 2015

SENATE BILL

No. 137

Introduced by Senator Hernandez

January 26, 2015

An act to add Section 1367.27 to, and to repeal Section 1367.26 of, the Health and Safety Code, and to add Section 10133.15 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 137, as amended, Hernandez. Health care coverage: provider directories.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of the act is a crime. Existing law requires a health care service plan to provide a list of contracting providers within a requesting enrollee's or prospective enrollee's general geographic area.

Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires health insurers subject to regulation by the commissioner to provide group policyholders with

a current roster of institutional and professional providers under contract to provide services at alternative rates.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. One of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed health care plans.

This bill, commencing July 1, 2016, would require a health care service plan, and a health insurer that contracts with providers for alternative rates of payment, to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees or the health insurer's insureds, and would require the plan or health insurer to make an online provider directory or directories available on the plan or health insurer's Internet Web site, as specified.

This bill would require the Department of Managed Health Care and the Department of Insurance to ~~jointly~~ develop uniform provider directory standards. The bill would require a health care service plan or health insurer to take appropriate steps to ensure the accuracy of the information contained in the plan or health insurer's directory or directories, and would require the plan or health insurer, at least annually, to review and update the entire provider directory or directories for each product offered, as specified. The bill would require a plan or insurer, at least weekly, to update its online provider directory or directories, and would require a plan or insurer, at least quarterly, to update its printed provider directory or directories. The bill would require a health care service plan or health insurer to reimburse an enrollee or insured for any amount beyond what the enrollee or insured would have paid for in-network services, if the enrollee or insured reasonably relied on the provider directory, as specified. *The bill would authorize a plan or health insurer to delay payment or reimbursement owed to a provider or provider group, as specified, if the provider or provider group fails to respond to the plan's or health insurer's attempts to verify the provider or provider group's information.* By placing additional requirements on health care service plans, the violation of which is a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1367.26 of the Health and Safety Code
2 is repealed.

3 SEC. 2. Section 1367.27 is added to the Health and Safety
4 Code, to read:

5 1367.27. (a) Commencing July 1, 2016, a health care service
6 plan shall publish and maintain a provider directory or directories
7 with information on contracting providers that deliver health care
8 services to the plan's enrollees, including those that accept new
9 patients. A provider directory shall not list or include information
10 on a provider that is not currently under contract with the plan.

11 (b) A health care service plan shall provide the directory or
12 directories for the specific network offered for each product using
13 a consistent method of network and product naming, numbering,
14 or other classification method that ensures the public, enrollees,
15 potential enrollees, the department, and other state or federal
16 agencies can easily identify the networks and plan products in
17 which a provider participates. By July 31, 2017, or 12 months after
18 the date provider directory standards are developed under
19 subdivision (k), whichever occurs later, a health care service plan
20 shall use the naming, numbering, or classification method
21 developed by the department pursuant to subdivision (k).

22 (c) (1) An online provider directory or directories shall be
23 available on the plan's Internet Web site to the public, potential
24 enrollees, enrollees, and providers without any restrictions or
25 limitations. The directory or directories shall be accessible without
26 any requirement that an individual seeking the directory
27 information demonstrate coverage with the plan, indicate interest
28 in obtaining coverage with the plan, provide a member
29 identification or policy number, provide any other identifying
30 information, or create or access an account.

31 (2) The online provider directory or directories shall be
32 accessible on the plan's public Internet Web site through an
33 identifiable link or tab and in a manner that is accessible and

1 searchable by enrollees, potential enrollees, the public, and
2 providers. By July 31, 2017, or 12 months after the date provider
3 directory standards are developed under subdivision (k), whichever
4 occurs later, the plan's public Internet Web site shall allow provider
5 searches by, at a minimum, name, practice address, city, ZIP Code,
6 California license number, National Provider Identifier number,
7 admitting privileges to an identified hospital, product, tier, provider
8 language or languages, provider group, hospital name, facility
9 name, or clinic name, as appropriate.

10 (d) (1) A health care service plan shall allow enrollees, potential
11 enrollees, providers, and members of the public to request a printed
12 copy of the provider directory or directories by contacting the plan
13 through the plan's toll-free telephone number, electronically, or
14 in writing. A printed copy of the provider directory or directories
15 shall include the information required in subdivisions (h) and (i).
16 The printed copy of the provider directory or directories shall be
17 provided to the requester by mail postmarked no later than five
18 business days following the date of the request and may be limited
19 to the geographic region in which the requester resides or works
20 or intends to reside or work.

21 (2) A health care service plan shall update its printed provider
22 directory or directories at least quarterly, or more frequently, if
23 required by federal law.

24 (e) (1) The plan shall update the online provider directory or
25 directories, at least weekly, or more frequently, if required by
26 federal law, when informed of and upon confirmation by the plan
27 of any of the following:

28 (A) A contracting provider is no longer accepting new patients
29 for that product, or an individual provider within a provider group
30 is no longer accepting new patients.

31 (B) A provider is no longer under contract for a particular plan
32 product.

33 (C) A provider's practice location or other information required
34 under subdivision (h) or (i) has changed.

35 (D) Upon completion of the investigation described in
36 subdivision (o), a change is necessary based on an enrollee
37 complaint that a provider was not accepting new patients, was
38 otherwise not available, or whose contact information was listed
39 incorrectly.

1 (E) Any other information that affects the content or accuracy
2 of the provider directory or directories.

3 (2) Upon confirmation of any of the following, the plan shall
4 delete a provider from the directory or directories when:

5 (A) A provider has retired or otherwise has ceased to practice.

6 (B) A provider or provider group is no longer under contract
7 with the plan for any reason.

8 (C) The contracting provider group has informed the plan that
9 the provider is no longer associated with the provider group and
10 is no longer under contract with the plan.

11 (f) The provider directory or directories shall include both an
12 email address and a telephone number for members of the public
13 and providers to notify the plan if the provider directory
14 information appears to be inaccurate. This information shall be
15 disclosed prominently in the directory or directories and on the
16 plan's Internet Web site.

17 (g) The provider directory or directories shall include the
18 following disclosures informing enrollees that they are entitled to
19 both of the following:

20 (1) Language interpreter services, at no cost to the enrollee,
21 including how to obtain interpretation services in accordance with
22 Section 1367.04.

23 (2) Full and equal access to covered services, including enrollees
24 with disabilities as required under the federal Americans with
25 Disabilities Act of 1990 and Section 504 of the Rehabilitation Act
26 of 1973.

27 (h) A full service health care service plan and a specialized
28 mental health plan shall include all of the following information
29 in the provider directory or directories:

30 (1) The provider's name, practice location or locations, and
31 contact information.

32 (2) Type of practitioner.

33 (3) National Provider Identifier number.

34 (4) California license number and type of license.

35 (5) The area of specialty, including board certification, if any.

36 (6) The provider's office email address, if available.

37 (7) The name of each affiliated provider group currently under
38 contract with the plan through which the provider sees enrollees.

39 (8) A listing for each of the following providers that are under
40 contract with the plan:

1 (A) For physicians and surgeons, the provider group, and
2 admitting privileges, if any, at hospitals contracted with the plan.

3 (B) Nurse practitioners, physician assistants, psychologists,
4 acupuncturists, optometrists, podiatrists, chiropractors, licensed
5 clinical social workers, marriage and family therapists, professional
6 clinical counselors, qualified autism service providers, as defined
7 in Section 1374.73, nurse midwives, and dentists.

8 (C) For federally qualified health centers or primary care clinics,
9 the name of the federally qualified health center or clinic.

10 (D) For any provider described in subparagraph (A) or (B) who
11 is employed by a federally qualified health center or primary care
12 clinic, and to the extent their services may be accessed and are
13 covered through the contract with the plan, the name of the
14 provider, and the name of the federally qualified health center or
15 clinic.

16 (E) Facilities, including, but not limited to, general acute care
17 hospitals, skilled nursing facilities, urgent care clinics, ambulatory
18 surgery centers, inpatient hospice, residential care facilities, and
19 inpatient rehabilitation facilities.

20 (F) Pharmacies, clinical laboratories, imaging centers, and other
21 facilities providing contracted health care services.

22 (9) The provider directory or directories may note that
23 authorization or referral may be required to access some providers.

24 (10) Non-English language, if any, spoken by a health care
25 provider or other medical professional as well as non-English
26 language spoken by a qualified medical interpreter, in accordance
27 with Section 1367.04, if any, on the provider's staff.

28 (11) Identification of providers who no longer accept new
29 patients for some or all of the plan's products.

30 (12) The network tier to which the provider is assigned, if the
31 provider is not in the lowest tier, as applicable. Nothing in this
32 section shall be construed to require the use of network tiers other
33 than contract and noncontracting tiers.

34 (13) All other information necessary to conduct a search
35 pursuant to paragraph (2) of subdivision (c).

36 (i) A vision, dental, or other specialized health care service plan,
37 except for a specialized mental health plan, shall include all of the
38 following information for each provider directory or directories
39 used by the plan for its networks:

1 (1) The provider's name, practice location or locations, and
2 contact information.

3 (2) Type of practitioner.

4 (3) National Provider Identifier number.

5 (4) California license number and type of license, if applicable.

6 (5) The area of specialty, including board certification, or other
7 accreditation, if any.

8 (6) The provider's office email address, if available.

9 (7) The name of each affiliated provider group or specialty plan
10 practice group currently under contract with the plan through which
11 the provider sees enrollees.

12 (8) The names of each allied health care professional to the
13 extent there is a direct contract for those services covered through
14 a contract with the plan.

15 (9) The non-English language, if any, spoken by a health care
16 provider or other medical professional as well as non-English
17 language spoken by a qualified medical interpreter, in accordance
18 with Section 1367.04, if any, on the provider's staff.

19 (10) Identification of providers who no longer accept new
20 patients for some or all of the plan's products.

21 (11) All other applicable information necessary to conduct a
22 provider search pursuant to paragraph (2) of subdivision (c).

23 (j) (1) The contract between the plan and a provider shall
24 include a requirement that the provider inform the plan within five
25 business days when either of the following occur:

26 (A) The provider is not accepting new patients.

27 (B) If the provider had previously not accepted new patients,
28 the provider is currently accepting new patients.

29 (2) If a provider who is not accepting new patients is contacted
30 by an enrollee or potential enrollee seeking to become a new
31 patient, the provider shall direct the enrollee or potential enrollee
32 to *both* the plan for additional assistance in finding a provider and
33 ~~the provider shall provide information to the individual on how to~~
34 ~~contact~~ to the department to report any inaccuracy with the plan's
35 directory or directories.

36 (3) If an enrollee or potential enrollee informs a plan of a
37 possible inaccuracy in the provider directory or directories, the
38 plan shall promptly investigate, and, if necessary, undertake
39 corrective action within 30 business days to ensure the accuracy
40 of the directory or directories.

(k) (1) On or before December 31, 2016, the department shall develop uniform provider directory standards to permit consistency in accordance with subdivision (b) and paragraph (2) of subdivision (c) and development of a multiplan directory by another entity. Those standards shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2021. No more than two revisions of those standards shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) pursuant to this subdivision.

(2) In developing the standards under this subdivision, the department shall seek input from interested parties throughout the process of developing the standards and shall hold at least one public meeting. The department shall take into consideration any requirements for provider directories established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(3) By July 31, 2017, or 12 months after the date provider directory standards are developed under this subdivision, whichever occurs later, a plan shall use the standards developed by the department for each product offered by the plan.

(l) (1) A plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the plan's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered. Each calendar year the plan shall notify all contracted providers described in subdivisions (h) and (i) as follows:

(A) For individual providers who are not affiliated with a provider group described in subparagraph (A) or (B) of paragraph (8) of subdivision (h) and providers described in subdivision (i), the plan shall notify each provider at least once every six months.

(B) For all other providers described in subdivision (h) who are not subject to the requirements of subparagraph (A), the plan shall notify its contracted providers to ensure that all of the providers are contacted by the plan at least once annually.

(2) The notification shall include all of the following:

(A) The information the plan has in its directory or directories regarding the provider or provider group, including a list of

1 networks and plan products that include the contracted provider
2 or provider group.

3 (B) A statement that the failure to respond to the notification
4 may result in a delay of payment or reimbursement of a claim
5 pursuant to subdivision (p).

6 (C) Instructions on how the provider or provider group can
7 update the information in the provider directory or directories using
8 the online interface developed pursuant to subdivision (m).

9 (3) The plan shall require an affirmative response from the
10 provider or provider group acknowledging that the notification
11 was received. The provider or provider group shall confirm that
12 the information in the provider directory or directories is current
13 and accurate or update the information required to be in the
14 directory or directories pursuant to this section, including whether
15 or not the provider or provider group is accepting new patients for
16 each plan product.

17 (4) If the plan does not receive an affirmative response and
18 confirmation from the provider that the information is current and
19 accurate or, as an alternative, updates any information required to
20 be in the directory or directories pursuant to this section, within
21 30 business days, the plan shall take no more than 15 business
22 days to verify whether the provider's information is correct or
23 requires updates. The plan shall document the receipt and outcome
24 of each attempt to verify the information. If the plan is unable to
25 verify whether the provider's information is correct or requires
26 updates, the plan shall notify the provider 10 business days in
27 advance of removal that the provider will be removed from the
28 provider directory or directories. The provider shall be removed
29 from the provider directory or directories at the next required
30 update of the provider directory or directories after the 10-business
31 day notice period. A provider shall not be removed from the
32 provider directory or directories if he or she responds before the
33 end of the 10-business day notice period.

34 (5) *General acute care hospitals shall be exempt from the*
35 *requirements in paragraphs (3) and (4).*

36 (m) A plan shall establish policies and procedures with regard
37 to the regular updating of its provider directory or directories,
38 including the weekly, quarterly, and annual updates required
39 pursuant to this section, or more frequently, if required by federal
40 law or guidance.

1 (1) The policies and procedures described under subdivision (I)
2 shall be submitted by a plan annually to the department for
3 approval and in a format described by the department pursuant to
4 Section 1367.035.

5 (2) Every health care service plan shall ensure processes are in
6 place to allow providers to promptly verify or submit changes to
7 the information required to be in the directory or directories
8 pursuant to this section. Those processes shall, at a minimum,
9 include an online interface for providers to submit verification or
10 changes electronically and shall generate an acknowledgment of
11 receipt from the health care service plan. Providers shall verify or
12 submit changes to information required to be in the directory or
13 directories pursuant to this section using the process required by
14 the health care service plan.

15 (3) The plan shall establish and maintain a process for enrollees,
16 potential enrollees, other providers, and the public to identify and
17 report possible inaccurate, incomplete, or misleading information
18 currently listed in the plan's provider directory or directories. These
19 processes shall, at a minimum, include a telephone number and a
20 dedicated email address at which the plan will accept these reports,
21 as well as a hyperlink on the plan's provider directory Internet
22 Web site linking to a form where the information can be reported
23 directly to the plan through its Internet Web site.

24 (n) (1) This section does not prohibit a plan from requiring its
25 provider groups or contracting specialized health care service plans
26 to provide information to the plan that is required by the plan to
27 satisfy the requirements of this section for each of the providers
28 that contract with the provider group or contracting specialized
29 health care service plan. This responsibility shall be specifically
30 documented in a written contract between the plan and the provider
31 group or contracting specialized health care service plan.

32 (2) If a plan requires its contracting provider groups or
33 contracting specialized health care service plans to provide the
34 plan with information described in paragraph (1), the plan shall
35 continue to retain responsibility for ensuring that the requirements
36 of this section are satisfied.

37 (3) *A provider group may terminate a contract with a provider*
38 *for a pattern or repeated failure of the provider to update the*
39 *information required to be in the directory or directories pursuant*
40 *to this section.*

1 (4) A provider group is not subject to the payment delay
2 described in subdivision (p) if all of the following occurs:

3 (A) A provider does not respond to the provider group's attempt
4 to verify the provider's information. As used in this paragraph,
5 "verify" means to contact the provider in writing, electronically,
6 and by telephone to confirm whether the provider's information
7 is correct or requires updates.

8 (B) The provider group documents its efforts to verify the
9 provider's information.

10 (C) The provider group reports to the plan that the provider
11 should be deleted from the provider group in the plan directory
12 or directories.

13 (5) Section 1375.7, known as the Health Care Providers' Bill
14 of Rights, applies to any material change to a provider contract
15 pursuant to this section.

16 (o) (1) Whenever a health care service plan receives a report
17 indicating that information listed in its provider directory or
18 directories is inaccurate, the plan shall promptly investigate the
19 reported inaccuracy and, no later than 30 business days following
20 receipt of the report, either verify the accuracy of the information
21 or update the information in its provider directory or directories,
22 as applicable.

23 (2) When investigating a report regarding its provider directory
24 or directories, the plan shall, at a minimum, do the following:

25 (A) Contact the affected provider no later than five business
26 days following receipt of the report.

27 (B) Document the receipt and outcome of each report. The
28 documentation shall include the provider's name, location, and a
29 description of the plan's investigation, the outcome of the
30 investigation, and any changes or updates made to its provider
31 directory or directories.

32 (C) If changes to a plan's provider directory or directories are
33 required as a result of the plan's investigation, the changes to the
34 online provider directory or directories shall be made no later than
35 the next scheduled weekly update, or the update immediately
36 following that update, or sooner if required by federal law or
37 regulations. For printed provider directories, the change shall be
38 made no later than the next required update, or sooner if required
39 by federal law or regulations.

1 (p) (1) ~~Commencing July 1, 2017, notwithstanding~~
2 *Notwithstanding* Sections 1371 and 1371.35, a plan may delay
3 payment or reimbursement owed to a provider or provider group
4 as specified in subparagraph (A) or (B), if the provider or provider
5 group fails to respond to the plan's attempts to verify the ~~provider~~
6 *provider's* or provider group's information as required under
7 subdivision (l). The plan shall not delay payment unless it has
8 attempted to verify the provider's or provider group's ~~information~~
9 ~~by all means of communication available to the plan, including in~~
10 ~~writing, electronically, or by telephone.~~ *information. As used in*
11 *this subdivision, "verify" means to contact the provider or provider*
12 *group in writing, electronically, and by telephone to confirm*
13 *whether the provider's or provider group's information is correct*
14 *or requires updates.* A plan may seek to delay payment or
15 reimbursement owed to a provider or provider group only after
16 the 10-business day notice period described in paragraph (4) of
17 subdivision (l) has lapsed.

18 (A) For a provider or provider group that receives compensation
19 on a capitated or prepaid basis, the plan may delay *no more than*
20 *50 percent of* the next scheduled capitation payment for up to one
21 calendar month.

22 (B) For any claims payment made to a provider or provider
23 group, the plan may delay the claims payment for up to one
24 calendar month beginning on the first day of the following month.

25 (2) A plan shall notify the provider or provider group 10
26 business days before it seeks to delay payment or reimbursement
27 to a provider or provider group pursuant to this subdivision. If the
28 plan delays a payment or reimbursement pursuant to this
29 subdivision, the plan shall reimburse the full amount of any
30 payment or reimbursement subject to delay to the provider or
31 provider group ~~no~~ *according to either of the following timelines,*
32 *as applicable:*

33 (A) *No later than three business days following the date on*
34 *which the plan receives the information required to be submitted*
35 *by the provider or provider group pursuant to subdivision (l).*

36 (B) *At the end of the one-calendar month delay described in*
37 *subparagraph (A) or (B) of paragraph (1), as applicable, if the*
38 *provider or provider group fails to provide the information*
39 *required to be submitted to the plan pursuant to subdivision (l).*

1 (3) A plan may terminate a contract for a pattern or repeated
2 failure of the provider or provider group to alert the plan to a
3 change in the information required to be in the directory or
4 directories pursuant to this section.

5 (4) *A plan that delays payment or reimbursement under this*
6 *subdivision shall document each instance a payment or*
7 *reimbursement was delayed and report this information to the*
8 *department in a format described by the department pursuant to*
9 *Section 1367.035. This information shall be submitted along with*
10 *the policies and procedures required to be submitted annually to*
11 *the department pursuant to paragraph (1) of subdivision (m).*

12 ~~(4)~~

13 (5) With respect to plans with Medi-Cal managed care contracts
14 with the State Department of Health Care Services pursuant to
15 Chapter 7 (commencing with Section 14000), Chapter 8
16 (commencing with Section 14200), or Chapter 8.75 (commencing
17 with Section 14591) of the Welfare and Institutions Code, this
18 subdivision shall be implemented only to the extent consistent
19 with federal law and guidance.

20 (q) In circumstances where the department finds that an enrollee
21 reasonably relied upon materially inaccurate, incomplete, or
22 misleading information contained in a health plan's provider
23 directory or directories, the department may require the health plan
24 to provide coverage for all covered health care services provided
25 to the enrollee and to reimburse the enrollee for any amount beyond
26 what the enrollee would have paid, had the services been delivered
27 by an in-network provider under the enrollee's plan contract. Prior
28 to requiring reimbursement in these circumstances, the department
29 shall conclude that the services received by the enrollee were
30 covered services under the enrollee's plan contract. In those
31 circumstances, the fact that the services were rendered or delivered
32 by a noncontracting or out-of-plan provider shall not be used as a
33 basis to deny reimbursement to the enrollee.

34 (r) Whenever a plan determines as a result of this section that
35 there has been a 10-percent change in the network for a product
36 in a region, the plan shall file an amendment to the plan application
37 with the department consistent with subdivision (f) of Section
38 1300.52 of Title 28 of the California Code of Regulations.

39 (s) This section shall apply to plans with Medi-Cal managed
40 care contracts with the State Department of Health Care Services

1 pursuant to Chapter 7 (commencing with Section 14000), Chapter
2 8 (commencing with Section 14200), or Chapter 8.75 (commencing
3 with Section 14591) of the Welfare and Institutions Code to the
4 extent consistent with federal law and guidance and state law
5 guidance issued after January 1, 2016. Notwithstanding any other
6 provision to the contrary in a plan contract with the State
7 Department of Health Care Services, and to the extent consistent
8 with federal law and guidance and state guidance issued after
9 January 1, 2016, a Medi-Cal managed care plan that complies with
10 the requirements of this section shall not be required to distribute
11 a printed provider directory or directories, except as required by
12 paragraph (1) of subdivision (d).

13 (t) A health plan that contracts with multiple employer welfare
14 agreements regulated pursuant to Article 4.7 (commencing with
15 Section 742.20) of Chapter 1 of Part 2 of Division 1 of the
16 Insurance Code shall meet the requirements of this section.

17 (u) Nothing in this section shall be construed to alter a provider's
18 obligation to provide health care services to an enrollee pursuant
19 to the provider's contract with the plan.

20 (v) *As part of the department's routine examination of the fiscal*
21 *and administrative affairs of a health care service plan pursuant*
22 *to Section 1382, the department shall include a review of the health*
23 *care service plan's compliance with subdivision (p).*

24 ~~(v)~~

25 (w) For purposes of this section, "provider group" means a
26 medical group, independent practice association, or other similar
27 group of providers.

28 SEC. 3. Section 10133.15 is added to the Insurance Code, to
29 read:

30 10133.15. (a) Commencing July 1, 2016, a health insurer that
31 contracts with providers for alternative rates of payment pursuant
32 to Section 10133 shall publish and maintain provider directory or
33 directories with information on contracting providers that deliver
34 health care services to the insurer's insureds, including those that
35 accept new patients. A provider directory shall not list or include
36 information on a provider that is not currently under contract with
37 the insurer.

38 (b) An insurer shall provide the online directory or directories
39 for the specific network offered for each product using a consistent
40 method of network and product naming, numbering, or other

1 classification method that ensures the public, insureds, potential
2 insureds, the department, and other state or federal agencies can
3 easily identify the networks and insurer products in which a
4 provider participates. By July 31, 2017, or 12 months after the date
5 provider directory standards are developed under subdivision (k),
6 whichever occurs later, an insurer shall use the naming, numbering,
7 or classification method developed by the department pursuant to
8 subdivision (k).

9 (c) (1) An online provider directory or directories shall be
10 available on the insurer's Internet Web site to the public, potential
11 insureds, insureds, and providers without any restrictions or
12 limitations. The directory or directories shall be accessible without
13 any requirement that an individual seeking the directory
14 information demonstrate coverage with the insurer, indicate interest
15 in obtaining coverage with the insurer, provide a member
16 identification or policy number, provide any other identifying
17 information, or create or access an account.

18 (2) The online provider directory or directories shall be
19 accessible on the insurer's public Internet Web site through an
20 identifiable link or tab and in a manner that is accessible and
21 searchable by insureds, potential insureds, the public, and
22 providers. By July 1, 2017, or 12 months after the date provider
23 directory standards are developed under subdivision (k), whichever
24 occurs later, the insurer's public Internet Web site shall allow
25 provider searches by, at a minimum, name, practice address, city,
26 ZIP Code, California license number, National Provider Identifier
27 number, admitting privileges to an identified hospital, product,
28 tier, provider language or languages, provider group, hospital
29 name, facility name, or clinic name, as appropriate.

30 (d) (1) An insurer shall allow insureds, potential insureds,
31 providers, and members of the public to request a printed copy of
32 the provider directory or directories by contacting the insurer
33 through the insurer's toll-free telephone number, electronically,
34 or in writing. A printed copy of the provider directory or directories
35 shall include the information required in subdivisions (h) and (i).
36 The printed copy of the provider directory or directories shall be
37 provided to the requester by mail postmarked no later than five
38 business days following the date of the request and may be limited
39 to the geographic region in which the requester resides or works
40 or intends to reside or work.

1 (2) An insurer shall update its printed provider directory or
2 directories at least quarterly, or more frequently, if required by
3 federal law.

4 (e) (1) The insurer shall update the online provider directory
5 or directories, at least weekly, or more frequently, if required by
6 federal law, when informed of and upon confirmation by the insurer
7 of any of the following:

8 (A) A contracting provider is no longer accepting new patients
9 for that product, or an individual provider within a provider group
10 is no longer accepting new patients.

11 (B) A contracted provider is no longer under contract for a
12 particular product.

13 (C) A provider's practice location or other information required
14 under subdivision (h) or (i) has changed.

15 (D) Upon the completion of the investigation described in
16 subdivision (o), a change is necessary based on an insured
17 complaint that a provider was not accepting new patients, was
18 otherwise not available, or whose contact information was listed
19 incorrectly.

20 (E) Any other information that affects the content or accuracy
21 of the provider directory or directories.

22 (2) Upon confirmation of any of the following, the insurer shall
23 delete a provider from the directory or directories when:

24 (A) A provider has retired or otherwise has ceased to practice.

25 (B) A provider or provider group is no longer under contract
26 with the insurer for any reason.

27 (C) The contracting provider group has informed the insurer
28 that the provider is no longer associated with the provider group
29 and is no longer under contract with the insurer.

30 (f) The provider directory or directories shall include both an
31 email address and a telephone number for members of the public
32 and providers to notify the insurer if the provider directory
33 information appears to be inaccurate. This information shall be
34 disclosed prominently in the directory or directories and on the
35 insurer's Internet Web site.

36 (g) The provider directory or directories shall include the
37 following disclosures informing insureds that they are entitled to
38 both of the following:

1 (1) Language interpreter services, at no cost to the insured,
2 including how to obtain interpretation services in accordance with
3 Section 10133.8.

4 (2) Full and equal access to covered services, including insureds
5 with disabilities as required under the federal Americans with
6 Disabilities Act of 1990 and Section 504 of the Rehabilitation Act
7 of 1973.

8 (h) The insurer and a specialized mental health insurer shall
9 include all of the following information in the provider directory
10 or directories:

11 (1) The provider's name, practice location or locations, and
12 contact information.

13 (2) Type of practitioner.

14 (3) National Provider Identifier number.

15 (4) California license number and type of license.

16 (5) The area of specialty, including board certification, if any.

17 (6) The provider's office email address, if available.

18 (7) The name of each affiliated provider group currently under
19 contract with the insurer through which the provider sees enrollees.

20 (8) A listing for each of the following providers that are under
21 contract with the insurer:

22 (A) For physicians and surgeons, the provider group, and
23 admitting privileges, if any, at hospitals contracted with the insurer.

24 (B) Nurse practitioners, physician assistants, psychologists,
25 acupuncturists, optometrists, podiatrists, chiropractors, licensed
26 clinical social workers, marriage and family therapists, professional
27 clinical counselors, qualified autism service providers, as defined
28 in Section 10144.51, nurse midwives, and dentists.

29 (C) For federally qualified health centers or primary care clinics,
30 the name of the federally qualified health center or clinic.

31 (D) For any provider described in subparagraph (A) or (B) who
32 is employed by a federally qualified health center or primary care
33 clinic, and to the extent their services may be accessed and are
34 covered through the contract with the insurer, the name of the
35 provider, and the name of the federally qualified health center or
36 clinic.

37 (E) Facilities, including but not limited to, general acute care
38 hospitals, skilled nursing facilities, urgent care clinics, ambulatory
39 surgery centers, inpatient hospice, residential care facilities, and
40 inpatient rehabilitation facilities.

1 (F) Pharmacies, clinical laboratories, imaging centers, and other
2 facilities providing contracted health care services.

3 (9) The provider directory or directories may note that
4 authorization or referral may be required to access some providers.

5 (10) Non-English language, if any, spoken by a health care
6 provider or other medical professional as well as non-English
7 language spoken by a qualified medical interpreter, in accordance
8 with Section 10133.8 of the Insurance Code, if any, on the
9 provider's staff. ~~For purposes of this section, "qualified interpreter"~~
10 ~~means that the interpreter meets the proficiency standards~~
11 ~~established pursuant to subparagraph (H) of paragraph (2) of~~
12 ~~subdivision (c) of Section 1300.67.04 of Title 28 of the California~~
13 ~~Code of Regulations.~~

14 (11) Identification of providers who no longer accept new
15 patients for some or all of the insurer's products.

16 (12) The network tier to which the provider is assigned, if the
17 provider is not in the lowest tier, as applicable. Nothing in this
18 section shall be construed to require the use of network tiers other
19 than contract and noncontracting tiers.

20 (13) All other information necessary to conduct a search
21 pursuant to paragraph (2) of subdivision (c).

22 (i) A vision, dental, or other specialized insurer, except for a
23 specialized mental health insurer, shall include all of the following
24 information for each provider directory or directories used by the
25 insurer for its networks:

26 (1) The provider's name, practice location or locations, and
27 contact information.

28 (2) Type of practitioner.

29 (3) National Provider Identifier number.

30 (4) California license number and type of license, if applicable.

31 (5) The area of specialty, including board certification, or other
32 accreditation, if any.

33 (6) The provider's office email address, if available.

34 (7) The name of each affiliated provider group or specialty
35 insurer practice group currently under contract with the insurer
36 through which the provider sees insureds.

37 (8) The names of each allied health care professional to the
38 extent there is a direct contract for those services covered through
39 a contract with the insurer.

(9) The non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 10133.8 of the Insurance Code, if any, on the provider's staff. ~~For purposes of this section, "qualified interpreter" means that the interpreter meets the proficiency standards established pursuant to subparagraph (H) of paragraph (2) of subdivision (c) of Section 1300.67.04 of Title 28 of the California Code of Regulations.~~

(10) Identification of providers who no longer accept new patients for some or all of the insurer's products.

(11) All other applicable information necessary to conduct a provider search pursuant to paragraph (2) of subdivision (c).

(j) (1) The contract between the insurer and a provider shall include a requirement that the provider inform the insurer within five business days when either of the following occur:

(A) The provider is not accepting new patients.

(B) If the provider had previously not accepted new patients, the provider is currently accepting new patients.

(2) If a provider who is not accepting new patients is contacted by an insured or potential insured seeking to become a new patient, the provider shall direct the insurer or potential insured to *both* the insurer for additional assistance in finding a provider and ~~the provider shall provide information to the individual on how to contact~~ to the department to report any inaccuracy with the insurer's directory or directories.

(3) If an insured or potential insured informs an insurer of a possible inaccuracy in the provider directory or directories, the insurer shall promptly investigate and, if necessary, undertake corrective action within 30 business days to ensure the accuracy of the directory or directories.

(k) (1) On or before December 31, 2016, the department shall develop uniform provider directory standards to permit consistency in accordance with subdivision (b) and paragraph (2) of subdivision (c) and development of a multiplan directory by another entity. Those standards shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2021. No more than two revisions of those standards shall be exempt from the Administrative Procedure Act (Chapter

3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) pursuant to this subdivision.

(2) In developing the standards under this subdivision, the department shall seek input from interested parties throughout the process of developing the standards and shall hold at least one public meeting. The department shall take into consideration any requirements for provider directories established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(3) By July 31, 2017, or 12 months after the date provider directory standards are developed under this subdivision, whichever occurs later, an insurer shall use the standards developed by the department for each product offered by the insurer.

(l) (1) An insurer shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the insurer's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered. Each calendar year the insurer shall notify all contracted providers described in subdivisions (h) and (i) as follows:

(A) For individual providers who are not affiliated with a provider group described in subparagraph (A) or (B) of paragraph (8) of subdivision (h) and providers described in subdivision (i), the insurer shall notify each provider at least once every six months.

(B) For all other providers described in subdivision (h) who are not subject to the requirements of subparagraph (A), the insurer shall notify its contracted providers to ensure that all of the providers are contacted by the insurer at least once annually.

(2) The notification shall include all of the following:

(A) The information the insurer has in its directory or directories regarding the provider or provider group, including a list of networks and products that include the contracted provider or provider group.

(B) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p).

(C) Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m).

(3) The insurer shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider group is accepting new patients for each product.

(4) If the insurer does not receive an affirmative response and confirmation from the provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory or directories pursuant to this section, within 30 business days, the insurer shall take no more than 15 business days to verify whether the provider's information is correct or requires updates. The insurer shall document the receipt and outcome of each attempt to verify the information. If the insurer is unable to verify whether the provider's information is correct or requires updates, the insurer shall notify the provider 10 business days in advance of removal that the provider will be removed from the directory or directories. The provider shall be removed from the directory or directories at the next required update of the provider directory or directories after the 10-business day notice period. A provider shall not be removed from the provider directory or directories if he or she responds before the end of the 10-business day notice period.

(5) *General acute care hospitals shall be exempt from the requirements in paragraphs (3) and (4).*

(m) An insurer shall establish policies and procedures with regard to the regular updating of its provider directory or directories, including the weekly, quarterly, and annual updates required pursuant to this section, or more frequently, if required by federal law or guidance.

(1) The policies and procedures described under subdivision (l) shall be submitted by an insurer annually to the department for approval and in a format described by the department.

(2) Every insurer shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory or directories pursuant to this section. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and

1 shall generate an acknowledgment of receipt from the insurer.
2 Providers shall verify or submit changes to information required
3 to be in the directory or directories pursuant to this section using
4 the process required by the insurer.

5 (3) The insurer shall establish and maintain a process for
6 insureds, potential insureds, other providers, and the public to
7 identify and report possible inaccurate, incomplete, or misleading
8 information currently listed in the insurer's provider directory or
9 directories. These processes shall, at a minimum, include a
10 telephone number and a dedicated email address at which the
11 insurer will accept these reports, as well as a hyperlink on the
12 insurer's provider directory Internet Web site linking to a form
13 where the information can be reported directly to the insurer
14 through its Internet Web site.

15 (n) (1) This section does not prohibit an insurer from requiring
16 its provider groups or contracting specialized health insurers to
17 provide information to the insurer that is required by the insurer
18 to satisfy the requirements of this section for each of the providers
19 that contract with the provider group or contracting specialized
20 health insurer. This responsibility shall be specifically documented
21 in a written contract between the insurer and the provider group
22 or contracting specialized health insurer.

23 (2) If an insurer requires its contracting provider groups or
24 contracting specialized health insurers to provide the insurer with
25 information described in paragraph (1), the insurer shall continue
26 to retain responsibility for ensuring that the requirements of this
27 section are satisfied.

28 (3) *A provider group may terminate a contract with a provider*
29 *for a pattern or repeated failure of the provider to update the*
30 *information required to be in the directory or directories pursuant*
31 *to this section.*

32 (4) *A provider group is not subject to the payment delay*
33 *described in subdivision (p) if all of the following occurs:*

34 (A) *A provider does not respond to the provider group's attempt*
35 *to verify the provider's information. As used in this paragraph,*
36 *"verify" means to contact the provider in writing, electronically,*
37 *and by telephone to confirm whether the provider's information*
38 *is correct or requires updates.*

39 (B) *The provider group documents its efforts to verify the*
40 *provider's information.*

1 (C) *The provider group reports to the insurer that the provider*
2 *should be deleted from the provider group in the insurer's provider*
3 *directory or directories.*

4 (5) *Section 10133.65, known as the Health Care Providers' Bill*
5 *of Rights, applies to any material change to a provider contract*
6 *pursuant to this section.*

7 (o) (1) Whenever an insurer receives a report indicating that
8 information listed in its provider directory or directories is
9 inaccurate, the insurer shall promptly investigate the reported
10 inaccuracy and, no later than 30 business days following receipt
11 of the report, either verify the accuracy of the information or update
12 the information in its provider directory or directories, as
13 applicable.

14 (2) When investigating a report regarding its provider directory
15 or directories, the insurer shall, at a minimum, do the following:

16 (A) Contact the affected provider no later than five business
17 days following receipt of the report.

18 (B) Document the receipt and outcome of each report. The
19 documentation shall include the provider's name, location, and a
20 description of the insurer's investigation, the outcome of the
21 investigation, and any changes or updates made to its provider
22 directory or directories.

23 (C) If changes to an insurer's provider directory or directories
24 are required as a result of the insurer's investigation, the changes
25 to the online provider directory or directories shall be made no
26 later than the next scheduled weekly update, or the update
27 immediately following that update, or sooner if required by federal
28 law or regulations. For printed provider directories, the change
29 shall be made no later than the next required update, or sooner if
30 required by federal law or regulations.

31 (p) (1) ~~Commencing July 1, 2017, notwithstanding~~
32 ~~Notwithstanding~~ Sections 10123.13 and 10123.147, an insurer
33 may delay payment or reimbursement owed to a provider or
34 provider group for any claims payment made to a provider or
35 provider group for up to one calendar month beginning on the first
36 day of the following month, if the provider or provider group fails
37 to respond to the insurer's attempts to verify the provider's
38 information as required under subdivision (I). The insurer shall
39 not delay payment unless it has attempted to verify the provider's
40 or provider group's information by all means of communication

1 available to the insurer, including in writing, electronically, or by
2 telephone. information. As used in this subdivision, “verify” means
3 to contact the provider or provider group in writing, electronically,
4 and by telephone to confirm whether the provider’s or provider
5 group’s information is correct or requires updates. An insurer
6 may seek to delay payment or reimbursement owed to a provider
7 or provider group only after the 10-business day notice period
8 described in paragraph (4) of subdivision (l) has lapsed.

9 (2) An insurer shall notify the provider or provider group 10
10 days before it seeks to delay payment or reimbursement to a
11 provider or provider group pursuant to this subdivision. If the
12 insurer delays a payment or reimbursement pursuant to this
13 subdivision, the insurer shall reimburse the full amount of any
14 payment or reimbursement subject to delay to the provider or
15 provider group ~~no~~ according to either of the following timelines,
16 as applicable:

17 (A) No later than three business days following the date on
18 which the insurer receives the information required to be submitted
19 by the provider or provider group pursuant to subdivision (l).

20 (B) At the end of the one-calendar month delay described in
21 subparagraph (A) or (B) of paragraph (1), as applicable, if the
22 provider or provider group fails to provide the information
23 required to be submitted to the insurer pursuant to subdivision (l).

24 (3) An insurer may terminate a contract for a pattern or repeated
25 failure of the provider or provider group to alert the insurer to a
26 change in the information required to be in the directory or
27 directories pursuant to this section.

28 (4) An insurer that delays payment or reimbursement under this
29 subdivision shall document each instance a payment or
30 reimbursement was delayed and report this information to the
31 department in a format described by the department. This
32 information shall be submitted along with the policies and
33 procedures required to be submitted annually to the department
34 pursuant to paragraph (1) of subdivision (m).

35 (q) In circumstances where the department finds that an insured
36 reasonably relied upon materially inaccurate, incomplete, or
37 misleading information contained in an insurer’s provider directory
38 or directories, the department may require the insurer to provide
39 coverage for all covered health care services provided to the insured
40 and to reimburse the insured for any amount beyond what the

1 insured would have paid, had the services been delivered by an
2 in-network provider under the insured's health insurance policy.
3 Prior to requiring reimbursement in these circumstances, the
4 department shall conclude that the services received by the insured
5 were covered services under the insured's health insurance policy.
6 In those circumstances, the fact that the services were rendered or
7 delivered by a noncontracting or out-of-network provider shall not
8 be used as a basis to deny reimbursement to the insured.

9 (r) Whenever an insurer determines as a result of this section
10 that there has been a 10-percent change in the network for a product
11 in a region, the insurer shall file a statement with the commissioner.

12 (s) An insurer that contracts with multiple employer welfare
13 agreements regulated pursuant to Article 4.7 (commencing with
14 Section 742.20) of Chapter 1 of Part 2 of Division 1 shall meet the
15 requirements of this section.

16 (t) Nothing in this section shall be construed to alter a provider's
17 obligation to provide health care services to an insured pursuant
18 to the provider's contract with the insurer.

19 (u) *As part of the department's routine examination of a health*
20 *insurer pursuant to Section 730, the department shall include a*
21 *review of the health insurer's compliance with subdivision (p).*

22 ~~(tt)~~

23 (v) For purposes of this section, "provider group" means a
24 medical group, independent practice association, or other similar
25 group of providers.

26 SEC. 4. No reimbursement is required by this act pursuant to
27 Section 6 of Article XIII B of the California Constitution because
28 the only costs that may be incurred by a local agency or school
29 district will be incurred because this act creates a new crime or
30 infraction, eliminates a crime or infraction, or changes the penalty
31 for a crime or infraction, within the meaning of Section 17556 of
32 the Government Code, or changes the definition of a crime within
33 the meaning of Section 6 of Article XIII B of the California
34 Constitution.